

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1.
 - a. Whether there should be additional reimbursement for date of service 10/12/01?
 - b. The request was received on 02/04/02.

II. EXHIBITS

1. Requestor, Exhibit 1:
 - a. TWCC-60 and Letter Requesting Dispute Resolution dated 02/27/02
 - b. HCFAs
 - c. EOBs
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Based on Commission Rule 133.307 (g)(4), the Division notified the insurance carrier Austin Representative of their copy of the request on 03/04/02. The Respondent did not submit a response to the request. The "No Response Submitted" sheet is reflected in Exhibit 2 of the Commission's case file.
3. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: letter dated 02/27/02
"We did bill these charges per the TWCC Medicine Ground Rules and Fee Guidelines. We also showed documentation of what these services incurred for reconsideration, but (Carrier) did not acknowledge this as part of the appeal and they still have not paid."
2. Respondent: no response received

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1&2), the only date of service eligible for review is 10/12/01.
2. The carrier's EOB has the denial "N – NOT APPROPRIATELY DOCUMENTED * IDENTICAL NOTES SUBMITTED FOR EACH SESSION, NO DOCUMENTATION REGARDING PROGRESS SPECIFIC ACTIVITIES ONE ON ONE THERAPY AND MINUTES OF DURATION."

2. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code	MARS	REFERENCE	RATIONALE:
10/12/01	97530	\$70.00 (2 units)	\$0.00	N	\$70.00 (\$35.00 per 15 min. unit)	MFG, MGR (I)(A), CPT descriptor	The medical documentation for the DOS in dispute does not contain a direct statement from the HCP conducting the exclusive one-on-one therapy session and does not reflect the clinical (physical or mental) need for one-on-one therapy. Therefore, no reimbursement is recommended.
10/12/01	97110	\$140.00 (4 units)	\$0.00	N	\$140.00 (\$35.00 per 15 min. unit)	MFG, MGR (I)(A), CPT descriptor	The medical documentation for the DOS in dispute does not contain a direct statement from the HCP conducting the exclusive one-on-one therapy session and does not reflect the clinical (physical or mental) need for one-on-one therapy. Therefore, no reimbursement is recommended.
Totals		\$210.00	\$0.00				The Requestor is not entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 4th day of June 2002.

Larry Beckham
Medical Dispute Resolution Officer
Medical Review Division

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.